STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 2 - COVERAGE AND ELIGIBILITY

Citation	2.l Application, Determination of Eligibility and Furnishing Medicaid	
42 CFR 435.10 and Subpart J	(a)	The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility, and furnishing Medicaid.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation			
	2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)		
42 CFR 435.914 1902(a)(34) of the Act	(b)	(1)	Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or an application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in ATTACHMENT 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month in which the individual is first determined to be a qualified Medicare beneficiary. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and 1920 of the Act	X	(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. ATTACHMENT 2.6-A specifies the requirements for determination of eligibility for this group.
42 CFR 434.20	(c)		Deleted 2003 due to Medicaid Managed Care BBA regulations.

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MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation

2.1 Application, Determination of Eligibility and Furnishing Medicaid (Continued)

1902(a)(55) of the Act

(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADFC form except as permitted by HCFA instructions.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

MEDICAID VOLUNTARY PCCM/MCO PROGRAM

I. Eligibility

A. Eligible Categories

The State of Utah Voluntary Primary Care Case Management/Managed Care Organization (PCCM/MCO) Program will include all Medicaid eligibility categories living in the rural counties of Utah except those listed under I.B. The Voluntary (PCCM/MCO) program is limited to the 25 rural counties of Utah. The primary care provider, either as a PCCM or as a provider participating with an MCO, coordinates patient care and acts as a gatekeeper.

B. Eligibility Category Exemptions

The State of Utah Voluntary PCCM/MCO Program assures the exclusion of the following Medicaid eligible individuals from enrollment:

1. Individuals residing in a nursing facility or ICF/MR;

2. Individuals living in State institutions (State Hospital or State Developmental Center); and

3. Individuals who have an eligibility period that is only retroactive or for those months that their eligibility is retroactive.

II. Voluntary Enrollment

A. Clients are allowed to change their PCCM or MCO at any time, or they may disenroll from the Voluntary PCCM/MCO Program and move to the traditional fee-for-service program. Client disenrollment from the Voluntary PCCM/MCO Program is effective no later than the beginning of the next calendar month, as long as the request for disenrollment is made by the 20th of the previous month.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

MEDICAID VOLUNTARY PCCM/MCO PROGRAM (cont.)

B. Clients will have the choice of the traditional fee-for-service (FFS) Program or of enrolling in the Voluntary PCCM/MCO Program. If an MCO is not available in a county, the choice will be either traditional FFS or the selection of a PCCM, if one is available within that county.

1. Process

Either a Health Program Representative (HPR) employed by the Division of Health Care Financing or the local health department under contract with the Medicaid Agency will enroll Medicaid clients with participating PCCMs or MCOs. The Division of Health Care Financing will contract with the local health departments to recruit providers to enroll as Medicaid PCCMs or MCOs and to link Medicaid clients with participating PCCMs or MCOs.

2. Methodology

The HPR or local health department worker shall contact providers eligible to be PCCMs under the Voluntary PCCM/MCO Program and promote enrollment in the program using, at a minimum, the following methods:

a. contacting and explaining the program to potential PCCMs;

b. referring the potential PCCM to the appropriate Medicaid staff to initiate enrollment in the program;

c. maintaining a list of medical providers who are participating in the PCCM/MCO program;

d. assisting participating PCCMs with Medicaid claims and referral processes;

e. contacting medical institutions such as hospitals, clinics, etc., and medical support providers such as dentists, pharmacists, medical laboratories, etc., to explain the PCCM/MCO program as it relates to the institution or provider;

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

MEDICAID VOLUNTARY PCCM/MCO PROGRAM (cont.)

f. providing ongoing training, information, and education to medical care providers interested in participating in the PCCM/MCO program and to providers enrolled in the PCCM/MCO program.

The content of the voluntary enrollment sessions includes information as follows:

An explanation of the Medicaid program, including:

a. services covered under the PCCM/MCO Program and, when applicable, how to access them;

b. benefits covered by Medicaid, and how clients may access these services;

c. assistance to those Medicaid individuals who have selected a PCCM with the referral process to ensure that access to care is not impaired;

d. disenrollment and change policies and procedures assuring that clients may disenroll with or without cause at any time effective the following month after requesting disenrollment, with a clear explanation that enrollment is voluntary, and that the client may disenroll at any time with or without cause;

e. listing of providers (PCCMs and MCOs) available in the area.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

MEDICAID VOLUNTARY PCCM/MCO PROGRAM (cont.)

f. instructions for changing from one PCCM or MCO to another PCCM or MCO, or disenrollment from the Voluntary PCCM/MCO Program and into the traditional FFS program;

g. enrollee rights and responsibilities; and

h. grievance and appeal procedures (State Fair Hearing process), and the procedures for using them.

If the client would like to choose a PCCM/MCO, he or she will be asked to complete a form indicating the selection.

III. Geographic Areas

The Voluntary PCCM/MCO Program is limited to the 25 rural counties of Utah.

IV. Cost Sharing Consistent with Medicaid Regulations.

V. Program Administration

A. PCCM Credentials

Any PCCM who has signed a provider agreement with the Division of Health Care Financing will be considered for participation. In order to be a PCCM, the PCCM must:

1. provide comprehensive primary medical care to all Medicaid clients enrolled with the PCP;

2. provide patient access to medical care by providing referrals to specialists (excluding anesthesiologists, radiologists, and assistant surgeons);

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

MEDICAID VOLUNTARY PCCM/MCO PROGRAM (cont.)

3. provide 30-day notification to the Division of Health Care Financing, or to the local health department and to the Medicaid clients who the PCCM or MCO serves, if the PCCM or MCO decides to terminate being a primary care provider with Medicaid, so that continuity of care can be maintained;

4. agree to comply with all pertinent Medicaid regulations and State Plan standards regarding access to care and quality of services;

5. be available or have appropriate coverage for the Medicaid clients in the PCCM's practice;

6. meet general qualifications for enrollment as a Medicaid provider;

7. not refuse a selection or disenroll a participant, or otherwise discriminate against a participant solely on the basis of race, color, nationality, disability, age, sex, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

B. MCO Credentials

Any MCO that has a contract with the Division of Health Care Financing to provide services to Medicaid clients will be considered for participation. The MCO must adhere to all provisions in the contract between the MCO and the Division of Health Care Financing. The MCO must provide 30-day notification to the Division of Health Care Financing if the MCO decides to terminate being an MCO in one or more of the rural counties of Utah.

C. Compliance

The State further assures that all requirements of Section 1932 of the Social Security Act will be met. All relevant provisions are included in the agreement with the PCCM or in the contract with the MCO.

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MEDICAL ASSISTANCE PROGRAM

State: UTAH

SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

MEDICAID VOLUNTARY PCCM/MCO PROGRAM (cont.)

1. The State will monitor and oversee the operation of the Voluntary PCCM/MCO Program, assuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts or agreements agreed upon by Medicaid and the PCCMs or the MCOs.

2. The State will maintain a grievance and complaint process to track all complaints and grievances received from clients and providers about the Voluntary PCCM/MCO Program. All complaints and grievances will be analyzed and used for evaluation purposes.

3. Medicaid staff will provide technical assistance as necessary to ensure that the PCCMs and MCOs have adequate information and resources to comply with all requirements of the law and their agreements or contracts.

D. Interpretive Services

Interpretive services are available through the Division of Health Care Financing's contracts with agencies that provide medical interpretive services in a variety of languages. The PCCMs will access interpretive services as needed. MCOs are required under the contract with the Division of Health Care Financing to provide interpretive services.

E. Coordination with Out-of-Plan and Excluded Services

The State assures that the services provided within the PCCM/MCO Program and Medicaid-covered services excluded from the PCCM/MCO Program will be coordinated. The required coordination is specified in the State contract with the MCOs and in the agreement with the PCCMs.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

MEDICAID VOLUNTARY PCCM/MCO PROGRAM (cont.)

VI. Rates and Payments

A. PCP Rates

PCCMs participating in the Voluntary PCCM/MCO Program will be reimbursed on a fee-for-service basis. Rates will be the same as for rural fee-for-service providers. Medicaid physicians in the rural counties receive a greater reimbursement for evaluation and management procedure codes than the physicians in the urban counties.

B. MCO Rates

MCOs will be paid on a capitated basis. Rates will be established in negotiations between the Division of Health Care Financing and each MCO. State payments to MCOs will comply with federal regulations.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation

42 CFR 435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

__ Mandatory categorically needy and other required special groups only.

__ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

__ Mandatory categorically needy, other required special groups, and specified optional groups.

X Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(l0)(A)(ii)(XI), 1902(a)(l0)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation
435.10 and
435.403, and
1902(b) of the
Act, P.L. 99-272
(Section 9529)
and P.L. 99-509
(Section 9405)

2.3 Residence

Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain the residence permanently or maintain it as a fixed address.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation	2.4 Blindness
42 CFR 435.530(b) 42 CFR 435.531 AT-78-90 AT-79-29	All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation	2.5 Disability
42 CFR 435.121, 435.540(b) 435.541	All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.13.b. of ATTACHMENT 2.2-A of this plan.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation	2.6 Financial Eligibility
42 CFR 435.10 and Subparts G & H 1902(a)(l0)(A)(i) (III), (IV), (V), (VI), and (VII), 1902(a)(l0)(A)(ii) (IX), 1902(a)(l0) (A)(ii)(X), 1902 (a)(l0)(c), 1902(f), 1902(l) and (m), 1905(p) and (s), 1902(r)(2), and 1920	The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

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SECTION 2 - COVERAGE AND ELIGIBILITY (Continued)

Citation	2.7 Medicaid Furnished Out-of-State
431.52 and 1902(b) of the Act. P.L. 99-272 (Section 9529)	Medicaid is furnished under the conditions specified in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.